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QUESTIONS PRESENTED

Respondent modifies Petitioner's characterization of the questions presented as follows:

1. Whether general Medicare reimbursement regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite a contrary administrative rule issued by the Secretary of Health and Human Services to govern reimbursement of advance refunding losses.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in delaying full reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act and the Medicare statute.

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No. 93-1251

In The

Supreme Court of the United States

October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF FOR THE RESPONDENT

STATUTORY AND REGULATORY PROVISIONS INVOLVED

In addition to the statutes and regulations restated in the Brief for Petitioner ("Pet. Bf."):

1. 42 U.S.C. § 1395hh(a), provides as follows:

> (1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.
>
> (2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

2. The Medicare regulation implementing 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. Part 413, provides in pertinent part as follows:

> **Subpart A – Introduction and General Rules**
>
> **§ 413.5 Cost Reimbursement: General**
>
> (a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. * * *

> (b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:
>
> (1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement. * * *

STATEMENT OF THE CASE

Resolution of the questions presented in this case involves very few disputed points. There is no dispute between the parties as to the amount of Respondent's loss on advance refunding. Pet. Bf. 8, Joint Appendix ("J.A.") 26. It is also undisputed that this loss is a reimbursable cost under the Medicare program. Appendix to Petition for Writ of Certiorari ("Pet. App.") 2a. The parties likewise are in agreement that no Medicare regulations specifically address the reimbursement effect of an advance refunding loss. Pet. App. 20a. There is further no question that Petitioner's treatment of Respondent's advance refunding loss, as embodied in section 233 of the Provider Reimbursement Manual ("PRM"), is inconsistent with the immediate recognition of such a loss required according to generally accepted accounting principles ("GAAP"). Pet. Bf. 9, 10. The parties recognize that Respondent claimed Medicare reimbursement for its advance refunding approach consistent with this GAAP approach. Pet. Bf. 9. Finally, it is undisputed that the one other circuit

court addressing the proper Medicare treatment for an advance refunding loss, and all of the six other district courts similarly deciding the precise issue presented here, have determined that Petitioner is required by her own regulations to reimburse providers for these losses in the year of defeasance according to the GAAP approach.[1]

Because there is no question in this case that Respondent's loss on advance refunding is a reimbursable cost, the courts below concluded that the sole issue presented concerns the correct timing of reimbursement. As the U.S. Court of Appeals for the Sixth Circuit determined:

> It is undisputed that the hospital is entitled to reimbursement for reasonable advance refunding costs. There is a dispute, however, as to when and how reimbursement is to be made – in

[1] These cases, surprisingly not mentioned in Petitioner's Brief although discussed in her Petition for Writ of Certiorari at notes 7 and 9, are: *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994) (Appendix to Supplemental Brief for the Respondent in Opposition to Petition ("Supp. App.") A1-A13); *Methodist-Evangelical Hosp., Inc. v. Shalala*, 1993 WL 548830, CCH Medicare & Medicaid Guide ¶ 42,017 (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill. 1993); *St. John Hosp. v. Shalala*, CCH Medicare & Medicaid Guide ¶ 41,700 (E.D. Mich. Aug. 18, 1993); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hosp. v. Sullivan*, 1991 WL 104090, CCH Medicare & Medicaid Guide ¶ 40,227 (D. Me. April 25, 1991); *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985). *See also Henry County Memorial Hosp. v. Shalala*, 1994 WL 141973, CCH Medicare & Medicaid Guide ¶ 42,129 (S.D. Ind. Feb. 23, 1994) (court applies Medicare regulations and GAAP to recognize advance refunding gain in year of refinancing). Needless to say, there is no "conflict" among the federal courts on this issue as is suggested in the Petition at pages 11 and 14 n.9.

> a lump sum payable now, or in a series of payments stretched over the remaining life of the original bonds?

Pet. App. 2a. Likewise, the U.S. District Court for the Southern District of Ohio noted: "[t]he parties agree that the refinancing cost incurred by Guernsey Hospital is a cost which is reimbursable. * * * As noted above, the disagreement involves the timing of reimbursement." Pet. App. 19a-20a.

Respondent takes issue with Petitioner's characterization of the loss on Respondent's advance refunding as merely an "accounting" loss. Pet. Bf. 8.[2] Respondent incurred an actual loss at the time of its advance refunding in 1985. This loss included Respondent's payment of a call premium in the amount of approximately $300,000 into the trusteed escrow account for early retirement of

[2] Petitioner's claim that Respondent's advance refunding loss is only an "accounting" loss seems contrary to her position that such a loss is a reimbursable cost under the Medicare program. In any event, the courts have also rejected this notion.

> The Secretary finally argues that the Hospital's loss was not a cash loss but only a "paper" loss, suggesting that the Hospital has not, in fact, incurred any real costs attributable to Medicare reimbursement. I disagree. The Hospital incurred a larger debt from the second bond issue than from the first, as well as up-front costs related to the transaction. In addition, the loss incurred as a result of the advance refunding has weakened the Hospital's debt-to-equity ratio and may have placed it in a less desirable position for obtaining future financing. Consequently, the Hospital has indeed incurred present debt and related costs.

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,600-36,601.

the 1982 bonds in 1992. J.A. 15, 16. The advance refunding loss also included the Respondent's write-off of approximately $700,000 for its unamortized bond discount and financing costs associated with the 1972 and 1982 bonds (the "refunded bonds"). These costs, which Respondent actually paid in connection with the refunded bond transactions, include bond underwriter discounts, attorney and accountant fees, and feasibility study costs. J.A. 15. These two components of the loss were netted against the interest earned on escrow account funds to calculate the actual loss amount of $672,581. J.A. 16, 26. The Medicare portion of this loss at issue here is approximately $314,000. Pet. App. 4a.

Petitioner acknowledges that the advance refunding saved Respondent more than $12 million in debt service costs associated with the refunded bonds. Pet. Bf. 8. This savings, in the amount of $12,112,029, results from the lesser total interest expense for the Hospital Improvement Revenue Refunding Bonds, Series 1985 (the "refunding bonds") as compared to the sum total interest expense which Respondent would have had to pay for the refunded bonds. J.A. 76. The Medicare program also benefits from this substantial reduction in Respondent's debt service expenses since it means a corresponding decrease in Respondent's reimbursable interest costs. J.A. 14.

The advance refunding transaction discharged Respondent from any further obligation for the refunded bonds. Upon issuance of the refunding bonds, $16,011,200 was irrevocably deposited into an escrow fund which BancOhio National Bank, Ohio maintained as trustee for the benefit of the bondholders. J.A. 39-47. With the payment of that sum into the escrow account, the City of

Cambridge, the trustee and Respondent executed a release, dated February 27, 1985, whereby Respondent was discharged from any further obligations regarding the refunded bonds. J.A. 50-53; 9-11. Respondent's 1985 audited financial statements and tax return both report the full amount of the advance refunding loss. J.A. 12-14. Respondent's financial statements after 1985 make no mention of either the refunded bonds or the loss on advance refunding. J.A. 14-15.

Upon the advance refunding, the refunded bonds became an obligation of the trustee. The escrow agreement requires the trustee to apply the escrowed funds to pay bondholders principal and interest on the refunded bonds when due. J.A. 39-47. These future debt service payments are costs of the trustee and will be reported in the financial statements related to the trustee. J.A. 24-25.

PRM § 233 bound Community Mutual Insurance Company, the fiscal intermediary of Petitioner, to amortize Respondent's refinancing loss over the remaining life of the refunded bonds. Pet. App. 87a. The fiscal intermediary had no discretion to deviate from this reimbursement treatment for the loss on advance refunding. Admin. Rec. 357, 358. Petitioner failed to promulgate PRM § 233 with public notice and comment as prescribed under the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. Pet. Bf. 36.

Respondent and the fiscal intermediary adjudicated their dispute in an evidentiary hearing before the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo(h), in pertinent part, provides: "[t]he Board [PRRB] shall be composed of five members * * * . All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and

at least one of them shall be a certified public accountant." At the PRRB adjudication hearing, Respondent offered the testimony of Donald Huelskamp, C.P.A., the hospital's vice president of finance and chief financial officer, and Douglas Langenfeld, C.P.A., partner with the accounting firm of Ernst & Whinney (now Ernst & Young). Diane Andrews, audit supervisor, testified on behalf of the fiscal intermediary.

Respondent takes issue with Petitioner's statement that the PRRB did not directly address PRM § 233 in its decision. Pet. Bf. 10. The PRRB specifically observed that "PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component." Pet. App. 70a. The PRRB unanimously found in favor of Respondent and held as follows:

> The Board, after considering the facts, the parties' position papers, the evidence presented, the testimony at the hearing, and post-hearing briefs, finds that the Provider [Respondent] is entitled to take the full loss on the advance refunding of the [refunded] bonds in FY. [fiscal year] [19]85. The Board finds that the loss on defeasance is an allowable cost under 42 CFR 405.451 [redesignated as 42 C.F.R. § 413.9] and is to be reimbursed in its entirety in the fiscal year at issue. Under GAAP, the loss on defeasance was a cost incurred in FY 85. This accounting treatment conforms with the requirement found in: (1) 42 CFR 405.406 [42 C.F.R. § 413.20] – providers are to follow standardized accounting practices; and (2) 42 CFR 405.453 [42 C.F.R. § 413.24] – providers are to furnish adequate cost data based on the accrual method of accounting.

Pet. App. 69a.[3]

In its decision, the PRRB also directly addressed Petitioner's argument that the "economic realities" of the refinancing transaction require amortization. The PRRB first found that Respondent's advance refunding loss must be recognized in 1985 since this loss is tied to past periods in which the hospital was obligated under the refunded bonds, not future periods. Pet. App. 71a. The PRRB further determined that not only is Petitioner's economic reality argument without foundation in the Medicare regulations, but that Petitioner has asserted very different positions on this issue in the past.

> The problem with this approach is that while beguiling (who would want to be caught espousing economic unreality?!) it is not a principle embodied in any regulation nor is it required by statute. * * *
>
> Further, HCFA [the Health Care Financing Administration] has consistently rejected the

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[3] The PRRB's ruling in this case is consistent with its twelve other decisions addressing this precise issue. The PRRB decided in favor of the provider in each of the seven federal court decisions mentioned in note 1 above. The PRRB also ruled in favor of the provider in the following other advance refunding cases: *Dominican Santa Cruz Hosp., Santa Cruz, Ca. v. Blue Cross*, CCH Medicare & Medicaid Guide ¶ 40,120 (PRRB Aug. 16, 1990); *Michigan Osteopathic Medical Ctr. v. Shalala*, CCH Medicare & Medicaid Guide ¶ 40,369 (PRRB June 18, 1992); *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Ass'n*, CCH Medicare & Medicaid Guide ¶ 40,413 (PRRB Sept. 6, 1991); *St. Mary's Regional Medical Ctr. v. Aetna Life Ins. Co.*, CCH Medicare & Medicaid Guide ¶ 41,583 (PRRB July 1, 1993); and *Univ. of Michigan Hosps. v. Blue Cross & Blue Shield Ass'n*, CCH Medicare & Medicaid Guide ¶ 41,743 (PRRB Sept. 23, 1993).

> concept of economic reality argued by providers in cases regarding recapture of depreciation. In both the old and amended versions of the regulation providing for recapture of depreciation, HCFA has adopted a policy treatment which exactly coincides with that of GAAP. * * * Thus, the Administrator himself is inconsistent in his acceptance of and approach to the concept of economic reality.

Pet. App. 70a-80a.

In addition, the PRRB recognized the importance of having an accepted and consistent approach to reimbursement such as the one embodied in GAAP:

> It is clear then that if, in the absence of any defining regulation, a concept of economic reality was used to measure costs, the result would be reimbursement schizophrenia, with each provider and intermediary applying their own personal concept of economic reality. The wisdom of adopting some common measurement of costs such as GAAP (which the Secretary appears to have done in 42 CFR 405.406 [42 C.F.R. § 413.20]) is thus self-evident. The principles of GAAP are carefully defined and are thus less open to interpretation than an undefined concept of economic reality.

Pet. App. 80a.

By decision dated October 12, 1990, the HCFA Deputy Administrator reversed the ruling of the PRRB. Pet. App. 40a-53a. The Discussion and Evaluation section of this opinion makes no mention of either 42 C.F.R. §§ 413.20 or 413.24, the two regulations which the PRRB had found directed application of the GAAP approach in this case. While the Deputy Administrator did note that

"GAAP will usually provide a reasonably accurate calculation of the cost of delivering health services to a provider's patients," he concluded that the specific policy set forth in PRM § 233 compelled a different treatment. Pet. App. 45a-46a.

Based on a strained reading of the Medicare regulations and GAAP, the district court affirmed the decision of the Deputy Administrator. Focusing its analysis on 42 C.F.R. § 413.20, the district court concluded that, while providers are required to report their costs based on GAAP, Petitioner need not also reimburse providers based on the same principles when no regulation governs the cost at issue. Pet. App. 31a.

The district court further asserted that: "[i]f the evidence of record suggested that rational accountants could not disagree on this point, and that the only possible way of treating this cost was to recognize it in full in the year in which it was incurred, the Secretary's decision might be said to be arbitrary." Pet. App. 33a. What the district court failed to realize was that the record evidence did plainly indicate that rational accountants cannot disagree on the proper treatment of a loss on advance refunding. This treatment is mandated in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26 (1972) ("APB 26") which specifies that refinancing losses must be recognized in full in the year of the refinancing. J.A. 62-75. Accountants are without authority to express an unqualified opinion which contradicts APB 26. J.A. 21.

In a unanimous opinion, the court of appeals reversed the district court. The court of appeals determined that the applicable regulations require Petitioner to apply GAAP for reimbursement of advance refunding losses.

> Were it not for § 233 of the Provider Reimbursement Manual, any fair-minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Pet. App. 8a.

The court of appeals also rejected the notion that GAAP must be applied for cost reporting, but not cost reimbursement, purposes. The court of appeals concluded that there must be consistency between cost reporting and cost reimbursement so that the provider industry will know its costs of delivering medical services to program beneficiaries and will be able to predict reimbursement. Pet. App. 13a. The court of appeals went on to hold as follows:

> The "nexus" that exists in the regulations between cost reporting and cost reimbursement is too strong, in our view, to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act. Insofar as the decision issued by the district court in this case holds otherwise, the decision is reversed.

Pet. App. 13a. Petitioner's petition for rehearing was denied as no judge from the Sixth Circuit voted in favor of granting the same. Pet. App. 38a-39a.

SUMMARY OF ARGUMENT

The parties agree that the loss Respondent incurred through the advance refunding is a reimbursable cost under the Medicare program. The dispute in this case is

whether the applicable Medicare statutes, regulations and case law construing these provisions permit Petitioner to postpone payment for this reimbursable cost based on a PRM provision which issued without public notice and comment.

While typically an interpretation of Petitioner would be subject to deference on judicial review, such deference is not appropriate here. Since PRM § 233 defies the plain language of 42 C.F.R. §§ 413.20, 413.24 and 413.5, the Secretary's interpretation is entitled to no deference. Similarly, because the Secretary's interpretation turns on a question of law and is inconsistent with both the PRRB's conclusions and former positions of the Secretary, administrative deference is diluted.

42 U.S.C. § 1395x(v)(1)(A) compels the Secretary to promulgate by regulation her reimbursement methods and the items to be included as reimbursable costs under the Medicare program. The Secretary has promulgated no such regulation defining her method of reimbursement for advance refunding losses. The Medicare statute further directs the Secretary to consider reimbursement principles generally applied by national organizations in prescribing her reimbursement regulations. The American Hospital Association, one such national organization discussed in the legislative history of this statutory language, applies GAAP for cost reimbursement purposes.

The Sixth Circuit correctly applied the plain language of sections 413.20, 413.24 and 413.5 in determining that Respondent was entitled to reimbursement for the full Medicare portion of its advance refunding loss in 1985. Section 413.20 indicates that GAAP "are followed" and

changes in these practices will not be required to "determine costs payable under the principles of reimbursement." The GAAP approach requires current recognition of Respondent's loss in the year of the advance refunding. Section 413.24 further requires that a provider's costs be recognized "in the period in which they are incurred * * *." Respondent's advance refunding loss was "incurred" in 1985 according to GAAP. Finally, section 413.5 specifies that one of the "goals" of Medicare reimbursement principles is "current payment" of providers for their reimbursable costs.

PRM § 233 defies the plain language of sections 413.20, 413.24 and 413.5. Section 233 amortizes the advance refunding loss over the remaining life of the refunded bonds even though the refunded bonds are no longer on the books of Respondent and the hospital has been released from any further obligation with respect to these bonds. This amortized treatment is contrary to GAAP and fails to reimburse Respondent currently when its advance refunding loss was incurred.

The decision of the court of appeals that section 233 impermissibly amends the plain language of the Medicare regulations is consistent with all seven other federal court decisions which are precisely on point. *Mother Frances Hosp.*, 15 F.3d 423; *Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017; *Graham Hosp.*, 832 F. Supp. 1235; *St. John Hosp.*, CCH Medicare & Medicaid Guide ¶ 41,700; *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227; *Baptist Hosp.*, 767 F. Supp. 139; and *Ravenswood Hosp.*, 622 F. Supp. 338.

Finally, PRM § 233 constitutes an invalid "substantive" rule under both the APA and the Medicare statute.

Section 233 affects the reimbursement rights of Respondent and has been enforced as a rule of law to deny Respondent current payment for its otherwise reimbursable advance refunding loss. Section 233 further makes a substantive change in Petitioner's methods of reimbursement, the items included as reasonable costs and the scope of benefits under the Medicare program. Section 233 "interprets" no Medicare regulation or statute. While the Secretary undoubtedly has the authority to promulgate section 233 through public notice and comment as a regulation, her "problem, of course, is that she has not done so." Pet. App. 9a. PRM § 233 is therefore invalid and the court of appeals' decision should be affirmed.

ARGUMENT

Standard of Review

The APA standard of judicial review applies to decisions of Petitioner. 42 U.S.C. § 1395oo(f)(1). Under the APA, reviewing courts are to "hold unlawful and set aside agency action, findings, and conclusions found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; * * * (D) without observance of procedures as required by law; [or] (E) unsupported by substantial evidence." 5 U.S.C. § 706(2).

While Petitioner's regulatory interpretations normally are entitled to deference on review, this deference is not appropriate in this case. The "deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia * * *." *Am. Ship Building Co. v. N.L.R.B.*, 380 U.S.

300, 318 (1965).[4] There are a number of critical reasons why such deference to Petitioner's interpretation is not applicable here.

First, an agency interpretation, such as PRM § 233, cannot contravene the express wording of the agency's own regulations. The weight typically given to an agency interpretation obviously cannot apply where the interpretation is "inconsistent with the regulation." *Stinson v. U.S.*, ___ U.S. ___, 113 S.Ct. 1913, 1919 (1993). *See Public Employees Retirement Sys. of Ohio v. Betts*, 492 U.S. 158, 171 (1989) ("[N]o deference is due to agency interpretations at odds with the plain language of the statute itself. Even contemporaneous and longstanding agency interpretations must fall to the extent they conflict with statutory

[4] As the First Circuit asserted in *Mayburg v. Secretary of Health and Human Services*, 740 F.2d 100, 105 (1st Cir. 1984) (Breyer, J.):

> A different line of Supreme Court cases, however, cautions us that "deference" is not complete; sometimes a different, and more independent judicial attitude is appropriate. *Bureau of Alcohol, Tobacco & Firearms v. Federal Labor Relations Authority*, [464] U.S. [89], [97] (1983) (court reviewing agency interpretation of law should not "slip into judicial inertia" or "rubberstamp" the agency); *American Shipbuilding Co. v. NLRB*, 380 U.S. 300, 318 (1964) (deference owed to agency "cannot be allowed to slip into a judicial inertia"); *NLRB v. Brown Food Store*, 380 U.S. 278, 291 (1964) (reviewing courts "are not obliged to stand aside and rubber stamp" the agency); *NLRB v. Insurance Agents' International Union*, 361 U.S. 477, 499 (1960) (recognition of administrative power "cannot exclude all judicial review" of agency's actions); *see also NLRB v. Highland Park Manufacturing Co.*, 341 U.S. 322, 325-26 (1951); *Davies Warehouse Co. v. Bowles*, 321 U.S. 144, 156 (1944). (parallel citations deleted).

language."); *Presley v. Etowah Cty. Comm'n*, ___ U.S. ___, 112 S.Ct. 820, 832 (1992). In the Medicare context, "[w]here a PRM provision exceeds its purpose and conflicts with an existing regulation or statute, it is invalid under the APA." *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602.

For this reason, reviewing courts must closely compare the wording of the regulation and the agency's interpretation.

> [W]e must "examine the interpretation itself in light of the language of the regulations. The words must be reasonably susceptible to the construction placed upon them by the Secretary, both on their face and in light of their prior interpretation and application. The interpretation must sensibly conform to the purpose and wording of the regulations."

St. Elizabeth Community Hosp. v. Heckler, 745 F.2d 587, 592 (9th Cir. 1984) (citations omitted). The Sixth Circuit similarly has asserted:

> An administrative agency's interpretation of a regulation is valid, however, only if that interpretation complies with the actual language of the regulation. An agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through changes in interpretation unsupported by the language of the regulation.

Fluor Constructors v. Occupational Safety and Health Review Comm'n, 861 F.2d 936, 939 (6th Cir. 1988) (citations omitted). In this case, of course, Respondent maintains that PRM § 233 is inconsistent with the express wording of the Medicare regulations.

The Medicare regulations are clear and unambiguous regarding the application of GAAP. As the court of

appeals found below: "[t]he rule set forth in the manual ignores the structure of the regulations and assumes the existence of a regulatory ambiguity that we have not been able to detect." Pet. App. 11a-12a. *See also Mother Frances*, Supp. App. A-7 ("In light of GAAP, the manifest conclusion from reading these regulations is that the Hospital was entitled to full reimbursement for this advance refunding loss in 1987."); *Mercy Hospital*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602 ("The Secretary has explicitly promulgated regulations applying GAAP.") As explained in *St. Luke's Hosp. v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), another reason for rejecting an administrative interpretation arises when the underlying regulations are unambiguous:

> [W]e simply read the statute to mean what it says; we interpret the language literally, and we find no initial ambiguity. Furthermore, our detailed analysis convinces us that our initial, literal reading of the words is also consistent with the statute's history and purposes. As the Supreme Court has recently said, "deference" to the agency's view of a statute is appropriate only when the statute is ambiguous.

Id. at 331 (Breyer, J.).

Second, courts review questions of law in administrative proceedings on a *de novo* basis. The APA specifies that "the reviewing court," not the administrative agency, "shall decide all relevant questions of law." 5 U.S.C. § 706. *See Office of Communication of the United Church of Christ v. F.C.C.*, 707 F.2d 1413, 1422 n.12 (D.C. Cir. 1983) ("The APA appears to require *de novo* review of all questions of law * * * .") While judicial resolution of administrative appeals must consider the knowledge gained from agency experience, the "final meaning" to be applied to

statutory and regulatory language is purely the province of the judiciary. *F.T.C. v. Colgate Palmolive Co.*, 380 U.S. 374, 385 (1965). *See also Office of Communication*, 707 F.2d at 1422 ("Traditionally, in determining whether the Commission has acted within its legally delegated authority, courts accord only limited deference to an agency's interpretation of its own governing statute."); *Rose v. Dole*, 945 F.2d 1331, 1333 (6th Cir. 1991); *Phillips Petroleum Co. v. F.E.R.C.*, 786 F.2d 370, 374 (10th Cir. 1986), *cert. denied*, 479 U.S. 823 (1986). The sole question presented in this case, too, involves no disputed facts. Rather, it is a question of law concerning whether Petitioner's interpretation in PRM § 233 is consistent with the Medicare regulations.

Third, it is well established that a final agency determination is more suspect on review if another agency adjudicatory body had previously reached a contrary conclusion. *See Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 496 (1951); *Ohio Associated Tel. Co. v. N.L.R.B.*, 192 F.2d 664, 668 (6th Cir. 1951). This doctrine applies in situations such as this where the decisions of the PRRB and HCFA Deputy Administrator differ. As stated in *St. Luke's Hosp. v. Schweiker*, CCH Medicare & Medicaid Guide ¶ 31,501 (E.D. Pa. Aug. 12, 1981):

> [T]he fact that the administrator reversed a decision [of the PRRB] reached within the agency is sufficient to require close scrutiny by this court. This is especially so since the PRRB, a five member board, has members which are required by statute to be "knowledgeable" in the field of cost reimbursement. * * * It is not appropriate for the courts to afford the Secretary's position extreme deference.

A similar concern was articulated in *St. John's Hickey Memorial Hosp., Inc. v. Califano*, 599 F.2d 803, 813 n.18 (7th Cir. 1979).

> Here the plaintiff is not the beneficiary of the government program, but a necessary participant in carrying out the program. The Secretary is obligated by statute to reimburse all reasonable costs of such providers. It would be inappropriate to allow his subordinate [the HCFA Administrator] to be the final arbiter of what is reasonable, particularly when they have overruled the decision of the Provider Reimbursement Review Board which was set up to mediate disputes between providers and intermediaries acting for the agency.

See also Sentara-Hampton General Hosp. v. Sullivan, 980 F.2d 749, 758 (D.C. Cir. 1992) ("[S]ince the HCFA frequently overruled the PRRB's findings, the inconsistency between the PRRB and HCFA 'detracts substantially from the deference normally due an agency's interpretation of its own regulations.' "); *Ornda Healthcorp v. Shalala*, 1993 WL 566004, CCH Medicare & Medicaid Guide ¶ 41,975 (E.D. Ark. Oct. 5, 1993) (Petitioner's "decision is subject to particular scrutiny when, as here, she rejected the decision of the [PRRB].").

Fourth, administrative deference is diluted when the agency has in the past taken a conflicting interpretation to the one currently being advanced. In *Morton v. Ruiz*, 415 U.S. 199, 237 (1974), this Court indicated that "[w]e have recognized previously that the weight of an administrative interpretation will depend, among other things, upon 'its consistency with earlier and later pronouncements' of an agency. In this instance, the [agency's] somewhat inconsistent posture belies its present assertion." (citations omitted). *See also Bowen v. Am. Hosp. Ass'n*, 476

U.S. 610, 646 n.34 (1986) ("The fact that the agency's interpretation 'has been neither consistent nor longstanding substantially diminishes the deference to be given to [the agency's] present interpretation of the statute.' "); *Saint Mary of Nazareth Hosp. v. Schweiker*, 718 F.2d 459, 464 (D.C. Cir. 1983).

Petitioner's argument that the court of appeals erred in determining that she is required to apply GAAP in the absence of a specific regulation to the contrary is inconsistent with the Secretary's position in those cases where GAAP supports a denial of reimbursement. For example, in *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1180 (9th Cir. 1980), "[t]he Secretary refused reimbursement on the ground that under 'generally accepted accounting principles' (which the Secretary is mandated to apply where an issue has not been covered by agency regulations * * *) there were no reasonable costs incurred." The decision in that case further observed that "**[b]oth parties agree** that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply 'generally accepted accounting principles.' " *Id.* at 1181 (emphasis added). Thus, Petitioner's position in this action is not only inconsistent with the Medicare cost reimbursement regulations, it defies the Secretary's prior interpretation of those same regulations.[5]

Finally, the reimbursement treatment of an advance refunding loss espoused in PRM § 233 is particularly suspect when considering that every single one of the eight federal courts reviewing this issue have rejected the

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[5] As discussed *infra* at pages 27 and 28 of the text, the Secretary's interpretations of the Medicare regulations at issue have also fluctuated during the course of these proceedings.

amortization approach as inconsistent with the regulations. In perhaps an understatement, the Fifth Circuit noted in *Mother Frances* that "[t]his argument of the Secretary has not fared well in the federal courts." Supp. App. A-7. This uniform judicial rejection of Petitioner's interpretation itself repudiates her deference arguments. *See Mayburg*, 740 F.2d at 102.

The Medicare Statute

The Medicare provisions of the Social Security Act require Petitioner to promulgate by regulation her methods of determining reimbursable program costs. 42 U.S.C. § 1395x(v)(1)(A), in pertinent part, provides:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and **shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs** * * * (emphasis added)

Pet. Bf. 2. The obligatory nature of this statute indicates that Petitioner has little choice but to adopt her reimbursable cost methods through the APA as regulations. *See Good Samaritan Hosp. v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151, 2154 n.1 (1993). The parties agree that the Secretary's reimbursement method for advance refunding losses as embodied in PRM § 233 have not been promulgated in any regulation. Pet. Bf. 36.

Section 1395x(v)(1)(A) goes on to state as follows:

> In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers.

Regarding this provision, the court of appeals determined that "[w]e can safely assume 'national organizations' keep their books in accordance with 'generally accepted accounting principles.'" Pet. App. 6a.[6] The court of appeals noted, however, that "[t]he fact that the Secretary must 'consider' GAAP in prescribing her regulations does not mean that GAAP must be adopted in the regulations * * * ." *Id.*

Petitioner surprisingly contends that the "principles * * * applied by national organizations or established prepayment organizations" referenced in the Medicare statute "have nothing specifically to do with GAAP." Pet. Bf. 21.[7] Petitioner claims that she is not even obligated to "consider" GAAP in promulgating her reimbursement regulations. In support of this position, Petitioner refers

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[6] The Fifth Circuit in *Mother Frances* likewise made the self-evident observation that "[t]hese 'national organizations' utilize GAAP." *Mother Frances*, Supp. App. A-6.

[7] The district court below found that "[t]he Secretary agrees that the Medicare Act requires both reimbursement of reasonable costs **and consideration of GAAPs**." (emphasis added). Pet. App. 26a.

to certain publications of the American Hospital Association ("AHA"). Pet. App. 21. These publications detract from Petitioner's position instead of bolstering it. The AHA, *Principles of Payment for Hospital Care* (1963), for example, states as one of its fundamental reimbursement principles that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting."[8] This concept is nearly identical to the language of 42 C.F.R. § 413.20(a), which states "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed."

Likewise, the "Purpose and Scope" section of AHA, *Uniform Chart of Accounts and Definitions for Hospitals* (1959) indicates that the AHA has adopted the accrual basis of accounting as is specified pursuant to 42 C.F.R. § 413.24. The Accounting Principles Board, which issued APB 26, was not created until September, 1959, and did

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[8] In her brief, Petitioner acknowledges this principle in *Principles of Payment for Hospital Care* but misconstrues the commentary regarding the same. Pet. Bf. 21 n. 11. Petitioner selectively quotes from this commentary and omits the following two sentences:

> Any systematic payment program requires an orderly procedure of reporting in order that the payment program may be administered fairly and expeditiously. * * * Reimbursement at cost by third party agencies is dependent upon their knowledge of the procedures used in providing the data.

Ibid. at 6, 7. This commentary stresses the importance of tying uniform reporting to payment practices so that the reimbursement program will be "systematic" and predictable. The AHA's discussion is similar to the court of appeals' conclusion regarding the strong "nexus" which exists in the regulations between cost reporting and cost reimbursement. Pet. App. 13a.

not issue its first APB Opinion until November, 1962. Dr. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* (7th ed. 1991) p. 1-19. After its creation and the issuance of its pronouncements regarding GAAP, the AHA made clear that GAAP and APB Opinions are the recommended principles of accounting for hospitals.

> Use of inconsistent methods of accounting and of procedures adopted as a result of individual inclinations causes confusion and misunderstanding. This chapter therefore is concerned with generally accepted accounting principles recommended for hospitals. The principles and concepts recommended in the *Opinions* of the Accounting Principles Board and the Committee on Auditing Procedures of the American Institute of Certified Public Accountants (AICPA) and the AICPA *Hospital* Audit Guide should be used as references for specific questions.

AHA, *Chart of Accounts for Hospitals* (Rev. 1973). Thus, the court of appeals was obviously correct in its conclusion that national organizations such as the AHA adhere to GAAP.

Similarly, the comments of former Social Security Commissioner Ball as taken from the legislative history of the Medicare Act do not lend Petitioner the support she seeks. Commissioner Ball acknowledged that "the determination of reimbursable cost does require the acceptance and use of uniform definitions, accounting, statistics, and reporting." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 198 (1966). Commissioner Ball himself therefore noted GAAP's significant role in the development of Medicare payment regulations.

Finally, the legislative history of the Social Security Act indicates that reimbursement principles contrary to

GAAP were rejected. During Congressional consideration of reimbursement principles, "[t]he AHA argued very vigorously for establishing depreciation on a cost-of-replacement basis." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance,* 89th Cong., 2d Sess. (1966), p. 46. This depreciation method departs from GAAP which adopts a historical cost basis for depreciation. APB Statement No. 4 (1970), ¶ 164. This departure was cited by the Senate Committee on Finance as the ground for rejecting the AHA replacement value depreciation basis. "[A]lthough there was some merit in the argument for a replacement cost basis, the use of this basis was too much a departure from the most common practice." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance,* p. 46.

The Plain Language of the Medicare Regulations

42 C.F.R. § 413.20

The reimbursement regulations which the Secretary has promulgated pursuant to 42 U.S.C. § 1395x(v)(1)(A) are set forth at 42 C.F.R. Part 413. This part is entitled "Principles of Reasonable Cost Reimbursement * * *" and "sets forth regulations governing Medicare payment for services furnished to beneficiaries * * *." 42 C.F.R. § 413.1.

42 C.F.R. § 413.20(a) plainly states

> (a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.

In a curious change of position, Petitioner argues that the "standardized" accounting practices which "are followed" pursuant to section 413.20(a) do not refer to GAAP. Petitioner finds the provision ambiguous and proclaims that "Section 413.20(a) by its terms does not require use of GAAP." Pet. Bf. 27. Before the court of appeals, the Secretary interpreted this provision somewhat differently. The Secretary found that this same regulation: 1) "provides that Medicare providers shall utilize GAAP for reporting their costs to Medicare" (Sec. Ct. App. Bf. 21); 2) "indicates that standardized practices (GAAP) will not need to be changed to participate in Medicare" (*Id.*); and 3) means that "the accounting systems and GAAP will be utilized 'to arrive at an equitable and proper payment for services to beneficiaries.' " (*Id.* at 23).[9] After arguing below that section 413.20(a) refers to GAAP, Petitioner's contrary assertions now must be given short shrift as "[t]he courts may not accept appellate counsel's post hoc rationalizations for agency

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[9] Besides the seven other advance refunding cases cited in note 1 *supra,* federal courts have systematically interpreted section 413.20 as requiring the Secretary to apply GAAP in the absence of a regulation to the contrary. *See Charlotte Memorial Hosp. and Medical Ctr. v. Bowen,* 860 F.2d 595 (4th Cir. 1988); *HCA Health Services,* 869 F.2d 1179; *Nat'l Medical Enterprises v. Bowen,* 851 F.2d 291 (9th Cir. 1988); *Villa View Community Hosp. v. Heckler,* 720 F.2d 1086 (9th Cir. 1983); *Medical Society of South Carolina v. Heckler,* 1984 WL 48806, CCH Medicare & Medicaid Guide ¶ 33,651 (D.S.C. Feb. 27, 1984). The Secretary's suggestions to the contrary in the PRM uniformly have been rejected on judicial review. Pet. Bf. 30 n. 17.

orders." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988).

It is also important to note that even had Petitioner taken a consistent stance as to the meaning of standardized accounting practices in section 413.20, her position would not be a credible one. As Petitioner notes in her brief, "GAAP consists of principles established by certain 'standard setting organizations' and professional societies. * * * In the absence of an applicable formal standard from one of those organizations, what is 'generally accepted' depends on 'the consensus of the accounting profession' as manifested in treatises and other publications." Pet. Bf. 9 n.6. Respondent submits that there can be no more "widely accepted" or "standardized" accounting practices than GAAP since, by definition, it consists of the principles generally accepted in the profession.

APB 26 is the GAAP controlling the treatment of advance refunding transactions such as the one at issue here. J.A. 62-75. APB 26 was promulgated to address the accounting profession's concerns that similar types of debt extinguishment transactions be dealt with consistently. Pet. App. 32a. APB 26 requires current recognition of both advance refunding losses and gains: "A difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains * * * . Gains and losses should not be amortized to future periods." J.A. 71.[10] APB 26 has been

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[10] The Financial Accounting Standards Board, Statements of Financial Accounting Standards No. 76 (Nov. 1983) ("FASB 76"), the other GAAP promulgation directly applicable herein,

the "law" for accountants since its adoption in 1972. J.A. 21, 74-75. It predates PRM § 233 by approximately eleven years. The three dissenting views of the eighteen members of the APB are entitled to no weight for financial accounting purposes. J.A. 23.

APB 26 explains the rationale for current recognition of a loss on advance refunding as follows:

> The change in the market value of the debt is caused by a change in the market rate of interest, but the change has not been reflected in the accounts. Therefore, the entire difference is recorded when the specific contract is terminated because it relates to the past periods when the contract was in effect. * * * Furthermore, a call premium necessary to eliminate an old contract and an unamortized discount or premium relate to the old contract and cannot be a source of benefits from a new debt issue. * * * When such debt originally issued at par is refunded, few accountants maintain that some portion of past interest should be capitalized and written off over the remaining life of the old debt or over the life of the new debt.

J.A. 65-66. In other words, because the loss relates entirely to the past term of the refunded bonds, it must be

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clarifies when debt is considered "extinguished" for the purposes of APB 26. FASB 76 indicates that such an extinguishment occurs where, as here, "[t]he debtor is legally released from being the primary obligor under the debt either judicially or by the creditor and it is probable that the debtor will not be required to make future payments with respect to that debt under any guarantees." Admin. Rec. at 625-26. There is no dispute in this case that Respondent's obligation under the refunded bonds was extinguished upon the advance refunding transaction. J.A. 9-11.

recognized at the time of the advance refunding when the refunded bond contracts are terminated. Pet. App. 71a.[11]

42 C.F.R. § 413.24

The next Medicare reimbursement regulation which the court of appeals relied on in rejecting PRM § 233 is 42 C.F.R. § 413.24. This regulation expressly provides that Medicare cost data "must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(b)(2) states: "Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period of which they are incurred, regardless of when they are paid." Under the accrual basis of accounting, advance refunding losses are "incurred" in the year of the refinancing.

Petitioner's suggestion that GAAP embodies a "particular version" of accrual accounting is without any authority. There are no "versions" of accrual accounting.

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[11] In its opinion, the PRRB equated the treatment of an advance refunding loss as specified in APB 26 with the accounting for a loss on the disposition of a depreciable asset.

> This treatment is similar to that which occurs when a fixed asset is disposed of and replaced before the end of its estimated useful life. Any loss on the disposal is clearly related to the old asset and not the replacement. The loss results from the fact that the actual depreciation in value of the asset differs from that recorded on the books. For that reason, the loss on disposal is treated as an allowable cost in the year of disposal. Likewise, the loss on defeasance should be treated as an allowable cost in the year of defeasance.

J.A. 72a; *see also* PRRB hearing testimony of Mr. Huelskamp and Mr. Langenfeld. J.A. 16-18.

Pet. Bf. 23. The treatise cited by the Petitioner in support of her argument clearly states that "Governments commonly use three bases of accounting: cash, accrual, and modified accrual." M. Dittenhofer, *Applying Governmental Accounting Principles* (1990) § 9.01. Modified accrual thus is not a "version" of the accrual basis of accounting, but a separate basis of accounting. Another treatise upon which Petitioner relies explains the modified accrual basis of accounting as follows:

> The modified accrual basis of accounting reflects the concept that a governmental fund is a means of providing accountability and is not concerned with the determination of net income, but only with the measurement of increases or decreases in available, spendable financial resources.

R. Kay & D. Searfoss, *Handbook of Accounting and Auditing*, p. 31-25 (2d ed 1989). Thus, the definition of modified accrual accounting is at odds with the definition of accrual accounting as adopted by section 413.24, which is concerned with recognizing financial transactions in the period when they occur regardless of the timing of cash flow. M. Dittenhofer, *Applying Governmental Accounting Principles* § 9.03.

The accrual basis of accounting, rather than the cash basis or modified accrual basis, is the standardized basis of revenue and cost reporting adopted by GAAP and by Petitioner's cost reimbursement regulations. Petitioner's argument that accrual accounting is not synonymous with GAAP is without merit. "Generally accepted accounting principles encompass the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time." APB Statement No. 4, ¶ 138 (1970). The pervasive principles of GAAP "specify the general approach accountants take to recognition and

measurement of events that affect the financial position and results of operations of enterprises." *Id.* at ¶ 143. "The pervasive measurement principles [of GAAP] establish the basis for implementing accrual accounting." *Id.* at ¶ 144. Section 413.24 requires that hospitals report costs and expenses in the year incurred. Standardized accounting principles, including those set forth in APB 26, require that advance refunding losses be reported as incurred in the year of the defeasance of the refunded debt.

It is irrational for Petitioner to suggest that "financial accounting" principles do not apply to reporting costs for Medicare reimbursement purposes. Pet. Bf. 23. The authorities cited by the Petitioner explain that:

> The primary objective of financial accounting is to provide individuals and groups external to management with financial and related information about the current status of the entity and the results of operations. * * * * [T]hese outside users will include * * * a variety of **government agencies**. (emphasis added).

D. Keller, J. Bulloch and R. Shultis, *Management Accountants' Handbook*, p. 1.1 (4th ed. 1992). The Medicare cost reimbursement regulations, 42 C.F.R. §§ 413.20 and 413.24, have plainly adopted financial accounting as the basis for cost finding and reporting.

The financial accounting principle of conservatism has no application to advance refunding transactions. APB 26 applies to both losses and gains. Thus, in a gain transaction, the entire gain will be reported in the year of the refunding transaction, contrary to the conservatism principle of understating net income. More important, the principle of conservatism, as explained below, applies

only to the measurement of gain or loss in the context of uncertainty.

> Frequently, assets and liabilities are measured in a context of significant uncertainties. Historically, managers, investors, and accountants have generally preferred that possible errors in measurement be in the direction of understatement rather than overstatement of net income and net assets. This has led to the convention of conservatism, which is expressed in rules adopted by the profession as a whole such as the rules that inventory should be measured at the lower of cost and market and that accrued net losses should be recognized on firm purchase commitments for goods for inventory. These rules may result in stating net income and net assets at an amount lower than would otherwise result from applying the pervasive measurement principles.

APB Statement No. 4, ¶ 171 (1970).

On the other hand, the loss or gain incurred in an advance refunding transaction involves no uncertainties. Petitioner recognizes that the amount of the loss or gain is the difference between the net carrying amount of the refunded debt and the amount Respondent was required to pay to the escrow trustee to defease the debt. Pet. Bf. 8 n.5. There is no dispute as to this amount. J.A. 26. When the advance refunding transaction is reported in the year of the refunding, there are no uncertainties as to the amount of gain or loss. Thus, there is no need to apply the accounting principle of conservatism.

The accounting measurement before this Court in *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522 (1979) was quite different than the measurement of gain or loss in an advance refunding transaction. *Thor Power Tool Co.* involved the income tax treatment of a loss resulting from

the write down of excess inventory. In the inventory write down at issue in *Thor Power Tool Co.*, unlike in the case of an advance refunding, there is no external transaction, such as a purchase or sale of inventory, that definitely establishes the value of inventory on hand. The conservatism principle at work in the write down of inventories has no application in the accounting treatment of executed financial transactions such as advance refundings.

In addition, the governing income tax regulations at issue in *Thor Power Tool Co.* differ significantly from the governing Medicare cost reimbursement principles at issue in this appeal. The PRRB's decision in this case carefully explains this distinction as follows:

> One of the governing regulations in *Thor* had provided that "[a] method of accounting which reflects the consistent application of generally accepted accounting principles . . . *will ordinarily be regarded* as clearly reflecting income." Emphasis added. This same regulation also provided that *"no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income."* Emphasis added. Yet another governing regulation provided that an inventory taken in conformity with best accounting practice "can, *as a general rule*, be regarded as clearly reflecting . . . income." Emphasis added.
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> In contrast to the tax code, the Medicare regulations, principally 42 C.F.R. 405.406, [413.20] do not appear to provide authority for the Administrator to reject the use of GAAP to determine actual cost.
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> * * *

> In addition 42 C.F.R. 405.453 [413.24] provides that "The cost data submitted must be based on the accrual basis of accounting which is recognized as the *most accurate basis for determining costs.*" Emphasis added.
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> This language is much stronger than that in *Thor* which, as indicated above, merely provided in part that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. Moreover, the Medicare regulations in question do not appear to provide the kind of authority for the Administrator to reject the use of GAAP to determine actual cost that the Supreme Court found in *Thor*. In fact, they appear to go beyond *Thor* in providing not merely a presumption but an actual requirement that determination of costs conform to generally accepted accounting principles.

Pet. App. 73a-76a. *See also Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602. Thus, the plain language of the Medicare cost reimbursement regulations do not give Petitioner the broad discretion to set aside standard accounting principles as did the plain language of the income tax code regulations at issue in *Thor Power Tool Co.*

Petitioner's reference to the Government Accounting Standards Board ("GASB") and Government Accounting Standard No. 23 likewise is not relevant to the issues before the Court. Government Accounting Standard No. 23 by its express terms applies only to government institutions that use proprietary fund accounting.[12] GASB 23

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[12] Even if GASB 23 was applicable to nongovernmental institutions, GASB 23 does not become effective until periods

at 23.03. It is undisputed in this case (1) that Respondent is not a governmental institution; (2) that the debt service costs of Respondent, not the debt service costs of City of Cambridge, are at issue in this case; and (3) that Respondent's loss on the advance refunding is an allowable Medicare cost. As a private, nongovernmental institution, Respondent is governed by the accrual accounting principles of GAAP and section 413.24, rather than the accounting principles of GASB.

42 C.F.R. § 413.5

The final reimbursement regulation directly applicable to this case is 42 C.F.R. § 413.5. This regulation appears in Subpart A of Part 413 which refers to "Introduction and General Rules." Section 413.5 itself refers to "Cost reimbursement: General." Section 413.5 is not discussed in Petitioner's brief even though the court of appeals quoted the same at length in its opinion. Pet. App. 7a.

Section 413.5 requires "current" payment of reimbursable costs. The regulation first indicates that "[i]n formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of **current costs** of the individual provider, rather than costs of a past period * * *." 42 C.F.R. § 413.5(a) (emphasis added). The regulation also provides that one of the "goals" of the "principles of reimbursement" is that "the methods of

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beginning after June 15, 1994. *Accounting and Financial Reporting for Refunding of Debt Reported by Proprietary Activities*, Statement of Government Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993) ("GASB 23") at 23.07.

reimbursement should result in **current payment** so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement." 42 C.F.R. § 413.5(b)(1) (emphasis added).

The Contrary Reimbursement Treatment Set Forth in PRM § 233

PRM § 233, unlike the treatment mandated in 42 C.F.R. §§ 413.20, 413.24 and 413.5, continues to tie Medicare reimbursement to the refunded bonds after the advance refunding occurs. Instead of accounting for the loss on advance refinancing currently in the year of refinancing, § 233 "recognize[s] any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately." Pet. App. 87a. PRM § 233 therefore defies the above regulatory requirements that payment be made according to GAAP and currently in the year when Respondent incurred its advance refunding loss.

The court of appeals below struck down section 233's amortized treatment of an advance refunding loss as inconsistent with 42 C.F.R. §§ 413.20, 413.24 and 413.5. After a very detailed analysis of the plain regulatory language, the court of appeals concluded that section 233 "ignores the structure of the regulations" and "[i]nsofar as the manual provision may represent an interpretation of the regulations, it is neither reasonable nor persuasive * * *." Pet. App. 11a-12a.

The other federal courts addressing the PRM's amortization of advance refunding losses have all come to this same conclusion. *Mother Frances Hosp.*, Supp. App. A-10 ("We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities."); *Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017 at 38,789 ("Section 233 also 'amends' §§ 413.20 and 413.24 by adding an exception to the application of generally accepted accounting principles."); *Graham Hosp.*, 832 F. Supp. at 1244 ("This Court agrees with the Sixth Circuit in its assessment that 42 C.F.R. Part 413 establishes a cost reimbursement policy consistent with GAAP, with which § 233 conflicts. Therefore, § 233 cannot be viewed as an interpretative rule which clarifies that policy."); *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602 ("The Secretary has explicitly promulgated regulations generally applying GAAP. In those circumstances where the Secretary chooses not to apply GAAP, he is free to promulgate regulations providing for another method of accounting and reimbursement. He has not done so for purposes of this case. It is not difficult to discern that § 215.1 [the PRM predecessor to § 233.3] – as a deviation from GAAP – flies in the face of the Secretary's own governing reimbursement regulations."); *Baptist Hosp.*, 767 F. Supp. at 141 ("[W]e hold that the Secretary's interpretation in the instant action may not be

adopted because it conflicts with the regulations requiring that GAAP be followed."); *Ravenswood Hosp.*, 622 F. Supp. at 344.

Petitioner's theories as to why all these court decisions are wrong are unavailing. Petitioner, for example, argues that the regulations only require that GAAP be applied to provider record-keeping and reporting, and that Petitioner is free to pay providers through any reimbursement methods she deems appropriate. Pet. Bf. 26, 27. This theory contravenes both the plain regulatory language and logic. Petitioner's argument blatantly ignores the "nexus" existing in the regulations between cost reporting and reimbursement. As the court of appeals observed:

> But the sentence in 42 C.F.R. § 413.20(a) that says standardized reporting practices "are followed" does not exist in a vacuum. The very first sentence of that section of the regulations begins with a reference to "[t]he principles of *cost reimbursement*." The sentence that comes immediately after the sentence prescribing use of standardized reporting practices says that changes in these standardized practices "will not be required in order to determine *costs payable* (by HHS) *under the principles of reimbursement*." The whole purpose of Part 413, as the introduction to that part explains, is to "set ( ) forth regulations governing Medicare payment" for services furnished, on a cost reimbursable basis, by hospitals and similar health care providers.

Pet. App. 11a.

The critical importance of the consistency between Medicare cost reporting and reimbursement to the provider industry has also been well established. The court

of appeals recognized "that the purpose of cost reporting is to enable a hospital's costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement." Pet. App. 13a (quoting *Fort Worth Osteopathic Medical Ctr.*, CCH Medicare & Medicaid Guide ¶ 40,413 at 31,848). Likewise, the *Mercy Hosp.* court asserted as follows regarding the Secretary's argument that GAAP only applies to provider record-keeping:

> The Secretary's argument is illogical. The Secretary mandates certain record keeping requirements precisely because the provider is entitled to reimbursement of reasonable costs. To suggest that the Secretary required providers to seek reimbursement under one accounting system while he intended to make payment under another is contrary to the structure of the regulations. (quotation omitted).

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,603. For these reasons, there is no merit to Petitioner's argument that GAAP governs provider record-keeping but not reimbursement of advance refunding losses.

Petitioner's suggestion that the reimbursement of a loss on advance refunding in a single year will result in cross-subsidization by Medicare of non-Medicare patients similarly is groundless and has been soundly rejected by the courts. Pet. Bf. 32.

> The Secretary's cross-subsidization argument rests on a faulty premise. The regulations cited by the Secretary relate to reasonableness of claimed costs. There has been no allegation that the Hospital has not properly allocated the

> claimed costs between Medicare and non-Medicare patients. The parties have agreed that the costs are reasonable and the only outstanding issue is timing: when should reimbursement be made.

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,600. The parties here, too, agree that Respondent has properly allocated the claimed advance refunding loss between Medicare and non-Medicare patients because the hospital is only claiming $314,000 of its $672,581 loss as a reimbursable cost under the Medicare program. Pet. App. 4a.[13]

The PRRB further specifically found that the loss on advance refunding relates solely to patient care in the year of defeasance, and thus gives rise to no cross-subsidizations between periods:

> The loss was related to patient care in 1985, the year of defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically

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[13] At note 18 of her brief, Petitioner voices the concern that Respondent could later "withdraw entirely from the program," thereby causing a maldistribution of reimbursement for the advance refunding loss between Medicare and non-Medicare patients. Suffice it to say, that such a withdrawal would be extremely unlikely since Respondent, like other provider hospitals, is committed to Medicare program participation with its continually aging patient base. Moreover, if Respondent's proportion of Medicare patient increases in the future, the Medicare program benefits through current payment instead of amortization.

> as losses or gains. Thus, there would have been no loss on the extinguishment of the debt. For that reason, the entire loss on defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Pet. App. 71a.

This undermines Petitioner's theory that the entire Medicare portion of Respondent's advance refunding loss is not an allowable cost in 1985. Pet. Bf. 31, 32. Indeed, there is no dispute in this case as to whether the loss is an allowable cost. The dispute instead centers on whether Petitioner can postpone payment for this reimbursable cost over the remaining life of bond issues to which Respondent is no longer a party. The regulations and GAAP provide a very clear answer to this "timing" question. According to the regulations and GAAP, the loss was "incurred" in 1985 and must be reimbursed currently in that year.[14]

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[14] This "timing" question at issue here is inapposite to the decisions which Petitioner cites in her Petition and Brief standing for the proposition that GAAP cannot make an otherwise unallowable cost reimbursable. These cases include *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir. 1984), *cert. denied*, 469 U.S. 823 (1984); *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201 (5th Cir. 1980), *cert. denied*, 450 U.S. 975 (1981); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701 (9th Cir. 1980); *Am. Medical Int'l, Inc. v. Secretary of Health, Educ. and Welfare*, 466 F. Supp. 605 (D.D.C. 1979), *aff'd on other grounds*, 677 F.2d 118 (D.C. Cir. 1981). The Fifth Circuit distinguished *Sun Towers*, and thereby these other decisions as well.

> In *Sun Towers*, the issue was *whether* a particular cost was allowable at all. In the case at bar, as it was in the *Guernsey* case, the issue is *when* a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that *Sun Towers* speaks to the issue of *when* reimbursement is to be made. (emphasis in original).

Supp. App. A-12. *Accord Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017 at 38,789 ("[E]ach of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement.").

Moreover, PRM § 233 assumes that the refunded bonds remain an obligation of Respondent instead of the trustee. J.A. 24-25. At the PRRB, Mr. Langenfeld addressed this point as follows:

> Section 233.3 is tying the recognition of the loss to future periods in treating the Provider as if the refunded debt was still on its books and treating it as if the hospital Provider was still a party to * * * the refunded debt issues. And I'm going to argue [that is] arbitrarily tying that to the activity within an escrow account to which the hospital is not a party and forcing the Provider to continue to amortize unamortized discounts and premiums on the old debt while at the same time the provider has incurred additional debt issue costs on the refunding debt and is amortizing those over the future. It's forcing recognition into the future for something that had happened * * * which the Provider cannot reverse in the current period.

J.A. 22.

Although Respondent has no further expenses or cost reporting related to the refunded bonds, PRM § 233 requires the hospital to report this as a reimbursable expense item in years after the advance refunding. This accounting fiction violates the specific reimbursement requirement contained in section 413.20(a) that the "methods of determining costs payable" will involve use

of the "institution's basi[c] accounts, as usually maintained * * * ." It also requires the Medicare program to reimburse Respondent for expenses the hospital does not otherwise incur in relation to non-Medicare patients in violation of the cross-subsidization principle discussed above. In addition, Petitioner's interpretation ignores that Respondent will already be paying reimbursable debt service for the refunding bonds in years subsequent to the advance refunding.

In addition, Petitioner's argument at footnote 10 of her Brief that PRM § 233 is consistent with sections 413.20 and 413.24 because those regulations were originally promulgated in 1967 before APB 26 was issued in 1972 is misleading and without merit. Standardized accounting practices, as required by section 413.20, are not fixed as of a certain date in time. "[GAAP] encompasses the conventions, rules and procedures necessary to define accepted accounting practice *at a particular time.*" APB Statement No. 4, ¶ 138 (1970). Section 413.20 requires that standardized accounting practices "that *are* widely accepted" be followed. (emphasis added). Section 413.20 does not require that only those standardized accounting practices that were widely accepted in 1966 be followed. APB 26 was issued in 1972 and it represents the widely accepted accounting standard for reporting losses on advance refunding transactions under the accrual basis of accounting. PRM § 233, which was issued in May, 1983, departed from the then widely accepted accounting standard for reporting advance refunding losses.

Finally, Petitioner attempts to draw an analogy between amortization of advance refunding losses and depreciation of capital assets. Pet. Bf. 32-34. She refers, for example, to *Research Medical Ctr. v. Schweiker*, 684 F.2d

599, 603 (8th Cir. 1982) where the court upheld a PRM section specifying that construction period "interest expense be capitalized over the useful life of the [hospital's] building (thirty years)." Petitioner ignores, however, that with depreciation and amortization of capital assets, there is an asset on the books of the provider. The cost of using that asset is spread over the periods during which that asset remains on the provider's books. There is no accepted accounting practice that would permit capitalizing and then amortizing an asset that is no longer in the possession of the provider or a liability that is no longer the obligation of the provider. Petitioner's depreciation analogy therefore fails.

PRM § 233 is a Substantive Rule Promulgated in Violation of the APA and Medicare Statute

The APA mandates specific statutory requirements for agency rulemaking. These familiar requirements include advance public notice of a proposed rulemaking through publication in the Federal Register and a public comment period for all interested persons. 5 U.S.C. § 553(b). The prescribed statutory rulemaking procedures serve vital public interests.

> Parties affected by the proposed legislative rule are the obvious beneficiaries of proper procedures. Prior notice and an opportunity to comment permit them to voice their objections before the agency takes final action. Congress enacted § 553 in part to "afford adequate safeguards to private interests." Given the lack of supervision over agency decisionmaking that can result from judicial deference and congressional inattention, this protection, as a practical

> matter, may constitute an affected party's only defense mechanism. * * *
>
> By the same token, public scrutiny and participation before a legislative rule becomes effective can reduce the risk of factual errors, arbitrary actions, and unforeseen detrimental consequences. * * *
>
> Finally, and most important of all, high-handed agency rulemaking is more than just offensive to our basic notions of democratic government; a failure to seek at least the acquiescence of the governed eliminates a vital ingredient for effective administrative action.

Chamber of Commerce of U.S. v. O.S.H.A., 636 F.2d 464, 470 (D.C. Cir. 1980) (citations omitted).

Under the APA, agencies cannot adopt "substantive" rules without adhering to the rulemaking procedures. A substantive, or "legislative," rule is one "affecting individual rights and obligations. This characteristic is an important touchstone for distinguishing those rules that may be 'binding' or have the 'force of law.' " *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979) (citations omitted). "Interpretative" rules, which may be issued without notice and comment pursuant to the APA, "do not have the force and effect of law" and merely "advise the public of the agency's construction of the statutes and rules which it administers." *Id.* at 302 n.31.

The Medicare statute imposes similar APA requirements of its own for substantive rules. 42 U.S.C. § 1395x(v)(1)(A) requires Petitioner to promulgate as **regulations** "the methods or methods to be used, and the items to be included, in determining such [reasonable] costs * * * ." 42 U.S.C. § 1395hh(a) likewise provides:

> No rule, requirement, or other statement of policy * * * that establishes or changes a substantive

> legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subsection shall take effect unless it is promulgated by the Secretary by regulation * * * .[15]

Based on the above, it is obvious that PRM § 233 constitutes a substantive rule. The interpretation affects the reimbursement rights of Respondent and has been enforced as a rule of law to deny Respondent current payment for its otherwise reimbursable loss on advance refunding. But for the Secretary's issuance of PRM § 233, Respondent would have received payment for its full Medicare portion of the loss in 1985 according to the existing and properly promulgated regulations. The amortized treatment of an advance refunding loss set forth in the PRM creates a complicated set of new rules that alter the reimbursement regulations calling for the current reimbursement of such a loss when the same was incurred. PRM § 233 makes a substantive change in Petitioner's methods of reimbursement, the items included as reasonable costs, and the scope of benefits and payment for services under the program.[16] As the court of appeals ruled, "§ 233 of the Providers Reimbursement Manual impermissibly changes the meaning of validly adopted

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[15] While section 1395hh was enacted after the effective date of section 233, this statute only magnifies the long-standing requirement contained in § 1395x(v)(1)(A) that the Secretary make substantive reimbursement changes by regulation.

[16] For this reason alone, PRM § 233 is a substantive rule regardless of the court of appeals' reading of the plain language of 42 C.F.R. §§ 413.20, 413.24 and 413.5.

regulations." Pet. App. 10a.[17] Since the Secretary elected to issue this substantive rule without public notice and comment according to the APA, PRM § 233 is invalid.[18]

The Secretary postulates that PRM § 233 interprets 42 C.F.R. § 413.9 – "Cost related to patient care." Pet. App. 47a. PRM § 233 itself makes no reference to any regulation it purportedly "interprets." Section 413.9, in turn, makes no mention of advance refunding losses or amortizing reasonable costs. This regulation instead merely reiterates that the Medicare program reimburses providers for their "reasonable costs." As Petitioner acknowledges, Respondent's loss on advance refunding is a reasonable cost. Section 413.9(b) does, however, restate the directive in 42 U.S.C. § 1395x(v)(1)(A) that the "[r]easonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." Since Petitioner has refused to promulgate a regulation setting forth her method of reimbursement for an advance

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[17] The court in *Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017 at 38,789, made a similar conclusion based on the four tests for a "substantive" rule recently articulated in *Am. Mining Congress v. Mining Safety & Health Admin.*, 995 F.2d 1106 (D.C. Cir. 1993).

[18] In note 21 of her brief, Petitioner claims certain organizations were consulted prior to the issuance of PRM § 233. Petitioner also admits that section 233 issued without APA notice and comment. Pet. Bf. 36. The fact the Secretary may have discussed the provision with certain external organizations prior to its inclusion in the PRM is irrelevant and outside of the record created before the PRRB. J.A. 3-5. Indeed, the input the Secretary purportedly received on section 233 from these selected groups highlights why formal notice and comment is necessary in this case.

refunding loss, PRM § 233 does not interpret section 413.9, but instead violates this regulation.[19]

Finally, Petitioner certainly has the option of seeking to promulgate section 233 as a regulation according to the APA's notice and comment procedures. The Secretary has promulgated by regulation other reimbursement methods which are contrary to GAAP. *See, e.g.*, 42 C.F.R. § 413.134(f)(2) (limitation on recognition of gain or loss on sale of depreciable asset contrary to GAAP approach); 42 C.F.R. § 413.153(b)(2) (provider's investment income offset against otherwise allowable interest expense contrary to GAAP). When the Secretary chooses to depart from the accepted and predictable cost reimbursement methods prescribed by GAAP, she must do so according to APA rulemaking. Because the Secretary has opted not to follow the mandated public notice and comment procedures in issuing PRM § 233, the manual provision is invalid. As the court of appeals aptly concluded: "we do not doubt that the Secretary would have the power to promulgate an actual regulation embodying the substance of § 233. The Secretary's problem, of course, is that she has not done so." Pet. App. 8a, 9a.

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[19] Petitioner incorrectly cites the language of 42 C.F.R. § 413.9(b) as applicable to this case. This regulatory provision is not helpful here since it only refers to the annual adjustment of estimated interim Medicare payments with the costs that providers actually incur each year. *See* 42 C.F.R. § 413.60.

CONCLUSION

The decision of the Sixth Circuit is based on the plain language of the applicable Medicare statutes and regulations. The court of appeals' ruling is also consistent with the overwhelming and one-sided federal case law directly on point. For these reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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